ISSN 0848-676X

Physician's newsletter

Published by the Medical Services Plan for Medical Practitioners

inside

Issue 1 Volume 25 Summer 2001

MSP Web site 1
Adjusted Clinical Groups 2
Dental Coverage Update 3
Billing Tips 3
New Addition to the Claims Information Line 3
Audit Reports 4
Medical Practitioners Amendment Act 5
Medical Imaging 5
List of Inserts 5
Replacement Codes for Explanatory Code "AF" 6
Lab Requisitions 6
New Pharmacare Low Cost Alternative/Reference Drug Program Booklet 6
The New B.C. "No CPR" Bracelet 7
MSP Premium Billing Initiatives 7
New and Modified Explanatory Codes 8
Medical Services Commission Funding Guidelines 10
Guidelines for the Use of Telemetry 11
Teleplan Support Centre 11
B.C. Palliative Care Benefits Program – Update 12
Updated list of Available Guidelines & Protocols 12
Amendment to MSP Radiology Categories 14
Update to the MSC Payment Schedule 15
Chronic Disease Management ... 19
MSP Bulletin 22

The Medical Services Plan web site – It's for you!

http://www.hlth.gov.bc.ca/msp

We know a busy professional like you needs internet information that's relevant and easy to access. That's why we're constantly upgrading the MSP web site to meet your needs. See what's available and check back often.

What's up:

- Complete listing of Guidelines and Protocols
- Phone numbers for specific areas within MSP
- The *MSC Financial Statement* (Bluebook)
- Information concerning coverage eligibility and premium options for patients
- Information about physician enrollment, claims submission and rural programs
- The *MSC Payment Schedule*
- The *Physician's Newsletter*
- Sections 5 and 6 of the *Physician's Resource Manual*

Under construction:

- MSP Tutor – interactive billing tutorials designed to provide you with information about how to bill claims to MSP effectively

tutor

For more information about MSP Tutor contact: Dianne Kirkpatrick (250) 952-1059 email: dianne.kirkpatrick@moh.hnet.bc.ca

ADJUSTED CLINICAL GROUPS (ACGs)

The year 2000 Practitioner Profile and BCMA Patterns of Practice Mini-Profile 2000 will mark the introduction of Adjusted Clinical Groups (ACGs) – developed at The Johns Hopkins University School of Public Health – as an estimator of statistically "expected" average per person cost of medical services. The incorporation of the ACG methodology is the latest development in the evolution of the (relatively new) whole patient reporting section of the practitioner profiles.

The ACG case-mix system incorporates both patient diagnosis and age and gender to characterise patient morbidity and estimate the medical care needed for the practitioner's patients. This is a significant improvement over using age and gender standardization alone for the purpose of comparing actual to expected costs. In peer reviewed and published evaluations, ACGs have been found to be up to five times more strongly correlated with patient resource use than age and gender alone.

ACGs measure health status by grouping all of a person's diagnoses collected from hospital separation records and fee-for-service claims (or other types of encounter records) into clinically meaningful groups. The multiple grouping processes used by the ACG case-mix system take a patient from ICD-9 diagnosis grouping down to a manageable set of Diagnostic Groups (ADGs). As an intermediate step, ADGs categorize morbidity over the spectrum of relatively small needs (such as single acute minor infection) to the most expensive (such as multiple unstable chronic conditions with acute complications). The combination of the number of ADGs that apply to the patient and a variety of other factors such as age and sex determine the patient's ACG. The ACG system assigns mutually exclusive categories of co-morbidity to each patient over a period of time, typically one year.

ACGs are based on the concept that morbidities (both related and seemingly unrelated) build on each other to determine the totality of an individual's illness level and need for health care services. At their core, ACGs attempt to account for the full range of morbidity types faced by patients over time rather than focusing on specific diagnoses that are most frequent or considered most important. This co-morbidity view has proven to be effective in profiling as an assessment of the need for medical services.

In both the Practitioner Profiles and the BCMA Patterns of Practice Mini-Profile the expected per person cost of medical services is calculated as the mean cost for patients in each ACG category. Individual expected costs (based on ACGs) are summed to obtain total expected medical costs for the patient population in a medical practice. This value is in turn used as the denominator in the practitioner's observed costs to expected costs ratio (O/E): a measure that takes into account patient morbidity when comparing a practitioner to his/her peer group. Although there is some patient variation not accounted for by ACGs, the ACG-based expected costs, when aggregated to the practice level, provide a useful comparison with observed costs.

In our profiles, actual medical costs and ACG expected medical costs incurred by a patient are broken out by levels of care including: patients receiving the majority of their care from the subject physician, those who are largely another physician's patients, and all patients to receive care from the physician. This breakdown not only gives a sense of where a physician's patients obtain their care, but also allows us to focus on those patients for whom the physician is most responsible.

For more information on ACGs please see the following article:

Performance of the ACG Case-Mix System in Two Canadian Provinces. Robert J. Reid, MD, PhD; Leonard MacWilliam, MSc, MNRN; Lorne Verhulst, MD, MPA; Noralou Roos, PhD; Michael Atkinson, BSc. Medical Care 2001; 39:86-99

You will also find information about ACGs on the following web sites:

http://acg.jhsph.edu/
http://www.umanitoba.ca/centres/mchpe/1mchpe.htm
http://www.lww-medicalcare.com/

DENTAL COVERAGE UPDATE

Dental Anaesthesia

On December 6, 2000, the Medical Services Commission approved a new policy for MSP coverage of dental anaesthesia. The new policy allows for coverage of dental anaesthesia services for non-cosmetic non-insured dental procedures for patients meeting specific eligibility criteria whether the dental procedure is performed in or out of hospital.

Under the new policy, if a non-insured, non-cosmetic procedure is required for the appropriate management of medically required dental needs of children, persons with disabilities, and people whose medical condition precludes the use of local anaesthesia, MSP will cover the anaesthesia regardless of the location in which the service is provided. The policy does not change existing benefits for anaesthesia services for patients who require hospitalization for the safe and efficient performance of a medically required MSP insured dental procedure.

Dental Extractions

The new Dental Extraction Policy, effective April 1, 2001, was developed in consultation with the Association of Dental Surgeons of British Columbia. The policy establishes dental and medical criteria used to determine when the extraction of impacted third molars or other teeth is an in hospital MSP insured service. Patients with a confirmed hospital dental extraction booking made prior to April 1, 2001, will be eligible for coverage although they may not meet the new criteria.

Request for Exceptions

Written requests for prior approval of patients requiring an exception to the criteria outlined in either policy should be sent to the Director, MSP Claims Branch fax (250) 952-3032. In the case of the Extraction Policy, MSP requires the operative surgeon to provide symptoms of dental/medical necessity for hospitalization and the proposed surgical fee item(s).

Contacts

If you have questions about these dental policies, contact the MSP Claims Billing Support Unit between 8:30 am and 4:30 pm at one of the following numbers Monday through Friday, and a client service representative will assist you with coverage questions.

Victoria	(250) 952-2654	Press 2 and press 2 again
Vancouver	(604) 806-0234	Press 2 and press 2 again
Rest of B.C.	(800) 563-5556	Press 2 and press 2 again

New Addition to the MSP Claims Information Line

The Billing Integrity Program is responsible for monitoring and investigating the billing patterns and practices of practitioners. If you would like more information about practitioner investigations or if you want to register a complaint, please choose Option 6 from the MSP Claims Information Line.

250-952-2654	Victoria
604-806-0234	Vancouver
1-800-563-5556	Toll Free

BILLING TIPS

Diagnostic and Therapeutic Procedures - Clarification of Clause B.11 A

The listings under the Diagnostic Procedures and Selected Therapeutic Procedures section of the *Payment Schedule* may be claimed in addition to a consultation or other assessment/visit, when performed during that visit. If the procedure takes place on a subsequent visit arranged to perform the procedure, then the visit may not be claimed in addition to the procedure unless the fee code for the latter is prefixed by the letter "Y" and the *Payment Schedule* does not preclude the claim. A subsequent visit fee will be paid in addition to the procedure if more than 30 days has elapsed between the initial visit and the diagnostic procedure.

Authorization for Surgery that Alters Appearance

Surgical service requests requiring pre-authorization, such as surgery for alteration of appearance, are held at MSP for 12 months after the authorization date. Surgery not performed within the 12 months requires a new authorization. To expedite your request, include a copy of the previous authorization with the current request, and advise if you have examined the patient since the original authorization was granted.

Fee Item T00357 – Trans-Esophageal Echocardiography

Fee item T00357 is a diagnostic ultrasound procedure. This procedure is not paid by MSP when performed in hospital for registered bed patients.

Audit Reports

General Practitioner - June 2000
An audit of a practice that was selected on a random basis indicated the doctor billed nursing home visits excessively, regardless of medical necessity. The matter was settled and the Medical Service Commission (MSC) was repaid $17,500 by the general practitioner in respect of the MSC's opinion that the doctor had departed unjustifiably from the pattern of practice of his peers.

Ophthalmologist - December 2000
MSP has reached a settlement with a specialist relating to a disputed pattern of billing. The review of billings was triggered by responses from the public to a service verification survey. A number of surcharges (fee item 1202) were apparently billed for electively scheduled consultations that occurred on weekends. Following negotiation, MSP accepted the practitioner's explanation of inadvertent error on the part of clerical staff. The parties agreed to repayment of $4,690 being the sum total of the errors.

Internal Medicine Specialist – December 2000
Following an audit, the MSC and a specialist physician reached a settlement in a dispute about billings regarding follow-up/minor consultations and emergency visit fees. The physician has agreed to make restitution of $13,000 inclusive of audit costs. The practitioner further agreed to adopt a pattern of practice directive in which the appropriate visit item will be billed rather than a consult item for follow-up visits after a consultation, and all essential elements of a consult including a report will be completed before the claim is submitted. The practitioner will also claim emergency visits only when there is a specific call to attend a patient on an urgent basis.

General Practitioner – February 2001
The MSP became aware of a problem with the billings of a general practitioner as a result of a service verification audit. A number of the respondents to the survey stated that they did not receive the services but that their spouse had been the patient. A further survey revealed that the nature of the problem was the billing of counselling for the spouse or partner of the practitioner's maternity patients. Following negotiation, the practitioner agreed to repayment in the amount of $4,490, covering a three-year period. The practitioner further agreed to abide by a pattern of practice directive in which counselling would not be claimed for advice that is a normal part of routine obstetrical care when that advice is provided to the spouse or partner of the maternity patient.

General Practitioner – February 2001
An audit of a general practitioner's billings was conducted and revealed inadequate documentation to support the billing for complete physical examinations that should have been billed as office visits. A settlement has been reached whereby the MSC will be repaid $40,000. The agreement requires that the doctor comply with the requirements for conducting complete physical examinations and maintain complete and legible clinical records in accordance with the *MSC Payment Schedule*.

General Practitioner – February 2001
An MSC audit of a general practitioner uncovered an inappropriate pattern of billing nursing home visits. The physician billed MSP for nursing home visits on the second Friday of each month, regardless of the number or date of actual services rendered. The physician has agreed to repay the MSC $15,000 inclusive of fees and audit costs.

As part of the settlement, the physician has agreed to make an adequate clinical record of every nursing home visit billed to MSP and to bill MSP only for medically necessary services actually rendered.

General Practitioner - March 2001
An audit was conducted on the practice of Dr. Michael Vagyi, a general practitioner, that identified concerns regarding the medical necessity and accuracy of billing for office visits, complete examinations, home visits, and out-of-office hour premiums. The audit also identified that there was insufficient documentation in the clinical records to substantiate a number of the submitted claims. As part of a settlement reached in March, 2001, Dr. Vagyi agreed to repay the MSC $250,000. In addition, Dr. Vagyi agreed to maintain adequate clinical records for each service billed to MSP and to only bill for services provided in accordance with the requirements as set out in the *MSC Payment Schedule*.

Medical Practitioners Amendment Act

A recent change to the *Medical Practitioners Act*, the *Medical Practitioners Amendment Act* (SBC 2001, Chapter 16), was passed into law on April 9, 2001. The changes prescribed in the new legislation have broadened the scope of "complementary medicine" therapies physicians can offer to their patients. However, these changes do not affect the Medical Services Commission's criteria for determining what services provided by medical practitioners will be a benefit of MSP. It is the responsibility of medical practitioners to advise patients at the time a "complementary" therapy or service is provided that the service will not be covered by MSP.

Physicians who wish to provide complementary therapies to their patients may want to review the Preamble to the *Medical Services Commission Payment Schedule*, established under Section 21 of the *Medicare Protection Act* and referred to in the *Master Agreement* between the Medical Services Commission and the British Columbia Medical Association (BCMA). Part A, Section 1 of the *MSC Payment Schedule* contains fees payable by the Medical Services Plan of British Columbia (MSP) for listed benefits. Physicians should be aware that benefits under the *Act* are limited to services which are medically required for the diagnosis and/or treatment of a patient, which are not excluded by legislation or regulation, and which are rendered personally by medical practitioners or by others delegated to perform them in accordance with the Commission's policies on delegated services.

Services requested or required by a third party for other than medical requirements are not insured by MSP. Services such as consultations, laboratory investigations, anaesthesia, surgical assistance, etc., rendered solely in association with other services which are not benefits of MSP are also not considered benefits of MSP.

In addition, new procedures and therapies not performed elsewhere and which involve a radical departure from the customary approaches to a medical problem are considered to be experimental medicine. Services related to experimental medicine are not benefits of MSP.

When a new therapy or procedure is being introduced into British Columbia and the physicians performing the new therapy or procedure want to have the service included in the *Payment Schedule*, an application for a new fee item related to the new therapy or procedure must be submitted by the appropriate section of the BCMA to the BCMA Tariff Committee for consideration with documentation supporting the introduction of this item into the *Payment Schedule*. If the Medical Services Commission, on the advice of the Tariff Committee, determines that the new therapy or procedure is not experimental medicine, the fee item application will be handled in the usual manner for a new fee.

The Medical Services Plan appreciates your cooperation in explaining MSP's payment policies to your patients who have questions about additional benefits related to the *Medical Practitioners Amendment Act*.

Medical Imaging

The Medical Imaging Division of the Diagnostic Accreditation Program (DAP) would like to remind physicians that a pertinent history and/or diagnosis is required on each requisition for an imaging study or procedure. Not only is this mandatory under the Medical Services Commission rules and DAP guidelines, it also ensures that the patient undergoes a study that can be "tailored" for the clinical situation. Often, additional or alternate views or even a different examination may be more suitable.

The imaging facility has the option of refusing to perform an examination if a requisition contains inadequate clinical information. Lack of an authorizing signature by the referring physician may also deem the requisition inadequate. In such instances the requisition should be returned to the referring physician. This causes inconvenience to the patient and may result in delayed diagnosis.

Submitted by: Dr. Henry Huey, Chair, Medical Imaging, Diagnostic Accreditation Program

List of Inserts

1) OOC policy
2) Primary Care Update
3) CareCard poster
4) No Show Poster
5) Coverage card
6) Teleplan Update
7) Chronic Disease Management (cover info & questionnaire)
8) BedLines Newsletter
9) MedicAlert (2 forms)
10) Pharmacare Update

Replacement Codes for Explanatory Code "AF"

AF – This patient does not have coverage for the DOS (date of service).

To clarify AF refusals, MSP has implemented the following specific explanatory codes, effective June 1, 2001.

*A Our records indicate patient deceased. Please contact MSP.

*B Patient's eligibility with MSP is in question. Please have patient contact MSP.

*C MSP is unable to locate patient. Please have patient contact MSP.

*D MSP has been unable to contact patient. Please have patient contact MSP.

*E Our records indicate patient has permanently moved out of B.C. Please contact MSP.

*F Patient has opted out of MSP. Patient should be billed directly.

*G Our records indicate MSP is not the primary insurer for this patient.

*H Our records indicate the patient requested coverage to be cancelled.

Note: Asterisk (*) is part of the explanatory code.

MSP has updated the electronic explantory code file to include the additional codes, if you require assistance please call:

Teleplan Support

Toll-Free	1-800-663-7206
Victoria	(250) 952-2668

Lab Requisitions

It has come to the attention of MSP that some patients are adding additional tests to the laboratory requisition that the physician has filled out. Since the patient has added these tests and not the referring physician, the services are not considered benefits under the *Medicare Protection Act*.

We suggest that practitioners check test results against the tests they have ordered on behalf of a patient. Since there are also permissible add-on tests performed by diagnostic facilities, practitioners should verify this with the diagnostic site.

If a practitioner becomes aware of a specific patient who is adding tests to requisitions, they are asked to notify MSP.

NEW PHARMACARE LOW COST ALTERNATIVE / REFERENCE DRUG PROGRAM BOOKLET

A new Low Cost Alternative/Reference Drug Program booklet became available on March 1, 2001. To streamline production, distribution, and cost of the booklet, it can be accessed and printed from the Pharmacare web site: **http://www.hlth.gov.bc.ca/pharme/lowcost.html**

Paper copies of the booklet will also be available upon request. To request a copy of the booklet, please contact the PharmaNet Help Desk:

In Victoria:	(250) 952-2866
Lower Mainland:	(604) 682-6849
Other areas of BC:	1-800-554-0250

THE NEW BRITISH COLUMBIA "NO CPR" BRACELET

Enclosed with this Newsletter is a copy of the new Ministry of Health/ BCMA No CPR Form and a one page order form for requesting copies of MedicAlert®'s new "No CPR Bracelet" brochure, which explains the process for ordering a No CPR bracelet.

Since the mid-nineties, British Columbians who have been diagnosed as having a terminal illness or are considered to be near the natural end of life have had the option of asking their physician to complete a Do Not Resuscitate (DNR) Order on a specified BCMA/Ministry of Health form. Beginning June 1, 2001, the Ministry of Health will replace the DNR Form with a No CPR Form (form HLTH302 1/NO CPR Revised 01/05/01). The new No CPR form includes references to the No CPR bracelet and reflects applicable consent provisions of the *Health Care (Consent) and Care Facility (Admission) Act*, which came into effect in February 2000. Physicians can order copies of the triplicate No CPR form from the Government's Product Distribution Services Customer Service at Fax: 250-952-4442.

To ensure a means of ready verification that a No CPR order is in place, the Ministry of Health and the British Columbia Medical Association have agreed to extend the DNR (in future the No CPR) protocol by adding a bracelet component. This means that any person for whom a DNR/NoCPR form has been completed will now be able to purchase a No CPR bracelet from the Canadian MedicAlert Foundation (MedicAlert®). A Vancouver philanthropist has kindly agreed to cover the cost of No CPR bracelets, to a maximum of $10,000, during the first two years of implementation for those individuals who are unable to pay for it themselves.

Please use the enclosed order form to obtain MedicAlert® brochures and keep the No CPR form for ready reference.

For information please contact Pieter de Groot, e-mail: pieter.degroot@moh.hnet.bc.ca.

MSP Premium Billing Initiatives

Effective February 2001, MSP introduced an option that allows beneficiaries to pay retroactive premiums and premiums in arrears through an installment plan. Most beneficiaries whose premium payment arrangements have terminated through an employer, union or pension plan will be automatically enrolled on a self-administered plan and billed for premiums from the date that their group-administered plan ended. If individuals do not receive notification within 60 days, they need to contact MSP. It is likely that their address with MSP is incorrect. It is important for beneficiaries to advise MSP immediately of address changes.

As in the past, premium assistance is offered to those with low incomes.

Residents of British Columbia who believe they may not be enrolled are asked to contact MSP at one of the following telephone numbers:

Lower Mainland	(604) 683-7151
Victoria	(250) 386-7171
Elsewhere in B.C.	1-800-663-7100

For general information or to request a form, visit our web site at: www.hlth.gov.bc.ca/msp

New and Modified Explanatory Codes

A9	PHN not approved for ICBC claim number.
BH	This claim will be processed on a future remittance statement. Please do not rebill.
CG	Each service must be on a separate line.
C9	WCB adjusted payment - premium only paid for electronically submitted forms.
D3	Payment withdrawn per debit request record.
EM	Service unrelated to MVA injury.
ET	WCB refused payment – fee item limit exceeded.
EW	WCB Adjustment - "E commerce fee" is paid on a WCB per diem/visit basis.
EX	This claim has been paid as a WCB account.
EY	WCB refusal. Area of injury not accepted on claim.
EZ	These fees are not a benefit when used for overtime compensation.
FP	This patient's care is restricted to another physician. Please refer to the MSP Bulletin.
JB	If a diagnostic procedure takes place on a subsequent visit within 30 days, only the diagnostic procedure is paid.
K9	Our records indicate that fee item 00114/00115 is not applicable, please verify patient's location.
J0	WCB refused – report submission incomplete, required information missing, worker's occupation missing.
J1	WCB refused – report submission incomplete, required information missing, clinic information (clinic name, area code or phone number missing).
J2	WCB refused – report submission incomplete, required information missing, report date missing.
J3	WCB refused – report submission invalid, specific reference number invalid or missing.
J4	WCB refused – report submission incomplete, required information missing, clinical information missing.
J5	WCB refused – report submission incomplete, required information missing, worker's city and or work location missing.
J6	WCB refused – report submission incomplete, required information missing, injury description missing.
J7	WCB refused – report submission incomplete, required information missing, patient duration missing.
J8	WCB refused – report submission incomplete, required information missing, disable from work flag missing.
J9	WCB refused – report submission incomplete, required information missing, Rehab program not indicated.
LE	Continuous care by a second anaesthetist is paid under time fees only.
LP	Fee Items 01151 and 13052 are not applicable when performed in conjunction with other anaesthetic services.
L1	WCB refused payment, practitioner not covered by a WCB service contract for this date of service. If clarification is required contact WCB Contract Services.
L2	WCB refused – duplicate form detected.

L3 WCB refused – report submission incomplete, required information missing, functional abilities.

L4 WCB refused – report submission incomplete, required information missing, injury status and objective findings.

L5 WCB refused – report submission incomplete, required information missing, report type missing.

L6 WCB refused – report submission incomplete, required information missing, recommendations missing.

L7 WCB refused – report submission incomplete, required information missing, initial visit date missing.

L8 WCB refused – report submission incomplete, required information missing, number of visits missing.

L9 WCB refused – report submission incomplete, required information missing, physician's surname and or given name missing.

M1 WCB refused – report submission incomplete, required info, regular practitioner indicator missing or invalid.

M2 WCB refused – report submission incomplete, required info, return to full duties indicator missing or invalid.

NG Additional prenatal visits must be supported by medical necessity.

OA Primary wound fees are only applicable with fees from the orthopaedic section.

QK Assistance at surgery/diagnostic procedures usually performed by one physician is not payable.

QY ICBC refusal, no refusal reason code.

RM The miscellaneous fee item billed has been changed to this established fee item.

T4 ICBC refused, this may be a WCB claim.

T5 Services exceed ICBC coverage limit.

T6 ICBC refused responsibility.

T7 Therapy treatment discontinued by medical practitioner, please contact ICBC.

T8 Claimant has private plan for therapy. Please contact ICBC.

UF Invalid MVA – no injury claim.

UG Breach of ICBC coverage.

UH MVA prior to April 1, 1994. Contact ICBC if necessary.

UI Duplicate KOL 35 – contact ICBC if necessary.

UJ No ICBC claim for PHN – use ICBC #. Contact ICBC if necessary.

UN WCB refused claim, Physiotherapy Plan/Report for home visit must have the same date of service as the first home visit.

UO WCB refused claim, Physiotherapy Plan/Report for CNS disorder must have the same date of service as the first central nervous disorder visit.

VX Medical practitioner referral required by ICBC. Please contact ICBC.

YC Claim number refused by ICBC.

Note: New explanatory codes are frequently being added - please update your Teleplan electronic explanatory code file monthly. Whenever you use a printed copy of explanatory codes you are most likely using an outdated list.

MEDICAL SERVICES COMMISSION FUNDING GUIDELINES

Out of Province and Out of Country Medical Care

Occasionally, it may be necessary to refer patients for elective medical care outside of British Columbia. On March 28, 2001 the Medical Services Commission (MSC) approved revisions to the Out of Province/Country Medical Care Funding Guidelines (OOC Guidelines) administered by the Medical Services Plan (MSP). The revised OOC Guidelines clarify the criteria for obtaining prior approval for funding of medically necessary OOC elective medical care and explain the procedure you will need to follow when making an application on behalf of your patient. Prior approval is necessary to ensure MSP is not paying for services that could be provided at a lesser cost in British Columbia or elsewhere in Canada. Coverage is not provided in cases where individual patients choose, on their own, to obtain medical care outside of the country.

- **Elective Medical Care outside of B.C. and within Canada:** Agreements for medical coverage are in place with all other provinces and territories (except Quebec), though some restrictions do apply. The policy provides a list of services not covered under the reciprocal agreements with other Canadian jurisdictions.
- **Emergency Services obtained outside of Canada** are paid at B.C. rates for beneficiaries travelling outside of Canada and prior approval is not necessary. B.C. residents are advised to buy additional insurance when travelling outside of Canada as medically necessary physician, dental/oral and facility services obtained outside of Canada may cost considerably more than the amount paid by MSP.
- **Non-emergency elective medical care outside of Canada** requires the prior approval of MSP. If appropriate and acceptable medically necessary care for your patient is available in B.C. or Canada, approval for OOC funding is rarely authorized. When making application on behalf of your patient, you are required to provide MSP with reasons why it is medically necessary to have the proposed medical care provided OOC.

Highlights of the Revised OOC Guidelines

- Specific information required by MSP to assess your application

Applications for prior approval must be submitted to MSP by an appropriate specialist actively involved in the beneficiary's care in B.C. An appropriate specialist is one with the most knowledge in the proposed service and/or specialty that will deliver the OOC medical care. Once the application is received by MSP, the appropriate specialist may be asked to submit additional information needed to make a decision.

Please note that:

- not all forms of medical care for all conditions are insured
- experimental and unproven medical care is not insured
- Incomplete applications, submitted directly by a beneficiary without a recommendation from an appropriate specialist will not be considered for OOC funding and are not eligible for a review by MSC

- **Clear administrative procedures to enable prompt handling of requests for medically necessary elective OOC medical care**
  In order for MSP to determine if funding for elective OOC medical care is warranted, an application for prior approval must be submitted to MSP prior to the provision of the service. In cases where OOC funding is appropriate, the prior approval process enables MSP to negotiate a reasonable and fair compensation rate from out of country service providers.
- **Information about MSP/MSC review processes.**

If MSP cannot approve your application, you and your patient will be advised of the reasons for the decision in accordance with the Guidelines. At that time, physicians may wish to provide additional relevant information to MSP and request an administrative review of the initial decision.

Following an administrative review by MSP, in which the initial decision is upheld, a beneficiary may request that the Medical Services Commission hold a Review Hearing to determine if MSP has applied the OOC Guidelines appropriately when making its decision on an application for OOC medical care.

MSP will review its initial decision at any time prior to an MSC Review Hearing if the appropriate specialist supplies additional relevant information to MSP.

In circumstances when a physician feels a particular medical situation does not fall within the scope of the Guidelines, physicians are welcome to contact:
Ms. Anne Morley, Out of Country Program Administrator
(250) 952-3426 for assistance.

Guidelines for the Use of Telemetry

The following notes are added to both the Diagnostic Radiology Preamble and Nuclear Medicine Preamble as follows:

Notes:
Radiology fees or nuclear medicine fees may only be claimed for studies performed by telemetry when:

i. the service meets existing Medical Services Commission (MSC) policy on the use of telemetry
ii. the use of telemetry will not negatively affect the existing on-site visit schedules of the radiologist or nuclear medicine specialist

MSC Policy on the Use of Telemetry

Definition of Telemetry: the electronic submission of data such as x-ray, nuclear medicine, ultrasound et al images.

For telemetry services to be considered as benefits under the Medical Services Plan:

- facilities (transmitting and receiving) must be specifically approved for telemetry by the Medical Services Commission (MSC); and,
- rendered at sites (transmitting and receiving) specifically accredited for telemetry by the Diagnostic Accreditation Program (DAP); and,
- the transmitting and receiving sites are located within active treatment hospitals which have been accredited by DAP and approved by MSC, and
- the services are rendered to out-patients, and
- the interpretations are performed by physicians specifically accredited by DAP and approved by MSC for the telemetry service rendered.

Billing Guidelines

- the service must be billed by the location where the image was taken using the practitioner number of the physician who did the interpretation*
- in those rare cases when a second radiological opinion is requested by the referring physician, a radiologist may bill for the service using fee item 08628, provided a written radiological report is sent to the referring physician.

* Exceptions

a) A physician who is required to travel from home to hospital in order to perform a telemetry service for an outpatient is entitled to bill service charges (fee items 01200 – 01202) when the *MSC Payment Schedule* criteria are met.

b) The original site should ensure that only one interpretation is billed to MSP.

Teleplan Support Centre

The Teleplan Support Branch provides technical and system support to all users of Teleplan including:

- electronic billing problems (software, hardware an network)
- password problems (resets passwords)
- zapping of claims billed with incorrect information
- technical problems
- reloads electronic mailbox
- electronic remittance statements and refusals

For assistance please call:
Victoria (250) 952-2668
Toll Free 1-800-663-7206

The telephone lines are operational from:
8:00 am until 5:00 pm

Except for on close-off:
8:00 am until 7:00 pm

BC Palliative Care Benefits Program – UPDATE

The B.C. Palliative Care Benefits program was introduced on February 1, 2001 and has been positively received, with an initial rapid enrollment of patients. As of April 30, 2001, the program has enrolled 1,462 persons, 371 have deceased, for a total program census of 1,091.

To ensure eligible patients are enrolled with this program and receive the available benefits, physicians should note:

- Application form must be faxed to Pharmacare's dedicated fax # 250-952-2861 and to your region's local home care office.
- The application form must be completed in its entirety, including patient's personal health number (PHN), their signature or their legal representative's signature, and physician information as well as the physician's signature to avoid delays in processing the application. (Incomplete forms are returned to the physician.)
- A prescription is needed for the eligible over the counter (OTC) drugs to be covered.

Any questions about the B.C. Palliative Care Benefits Program can be directed to the Project Manager, Ministry of Health, at 250-952-1092 or fax 250-952-1763.

PALLIATIVE CARE FORMULARY REVIEW - Ondansetron use in palliative care

The Palliative Care Formulary Committee has been requested to consider adding ondansetron to its formulary for use with palliative care patients. At this time, ondansetron has good evidence to support its use for chemotherapy-induced nausea and for large-field abdominal radiotherapy. Ondansetron is a restricted benefit under Pharmacare. For nausea and vomiting associated with cancer treatment, oncologists are exempt from Pharmacare's Special Authority coverage. All other physicians must request Special Authority coverage for their patients.

The use of ondansetron for nausea in palliative care patients who are not receiving chemotherapy is uncertain at this time due to lack of evidence. (Lipman AG, Jackson KC, Tyler LS (eds). Evidence Based Symptom Control in Palliative Care. The Haworth Press, New York, 2000, pgs 163-181). Ondansetron is an excellent antiemetic but, with limited palliative evidence base, its cost dictates that it be reserved for those with nausea that does not respond to other effective agents.

Updated List of Available Guidelines and Protocols

Topic	Guideline/Protocol
Ankle injury	X-ray for Acute Ankle Injury, Revised 2000
Bone density	Bone Density Measurement
Bone scans in prostate cancer	Investigation of Metastatic Bone Disease in Newly Diagnosed Prostate Cancer Using Nuclear Medicine Techniques, Reviewed and unchanged April 2000
Bone scans in suspected osteomyelitis	Investigation of Suspected Osteomyelitis in Normal Bone Using Nuclear Medicine Techniques, Reviewed and unchanged April 2000
Cataracts	Treatment of Cataract in Adults, Revised 2000
Chest x-rays	Chest X-rays in Asymptomatic Adults
Cholesterol	Cholesterol Testing: Adults Under 69 Years
Colonoscopy after colorectal cancer	Follow-up of Patients After Curative Resection of Colorectal Cancer
Diabetes, glucose and HbA_{1c}	Use of Glucose and HbA_{1c} Tests in Diagnosis and Monitoring of Diabetes Mellitus
Diarrhea	Investigation of Suspected Infectious Diarrhea
Dyspepsia	Clinical Approach to Adult Patients with Dyspepsia
ECGs	• Ambulatory ECG Monitoring (Holter Monitor and Patient-Activated Event Recorder) Revised 2001
	• Electrocardiograms, Revised 2000
ESR	Erythrocyte Sedimentation Rate, Revised 2000
Gallstones	Treatment of Gallstones in Adults
Gastroesophageal reflux disease	Clinical Approach to Adult Patients with Gastroesophageal Reflux Disease

(The maximum Pharmacare pays is $12.82 for the 4 mg tablet and $19.56 for the 8 mg tablet), clinical experience of the committee members suggests that the majority of patients can have good control of nausea with other agents but that there will be a minority of patients who may require ondansetron (or dolasetron) in addition to other multiple agents.

The following agents are suggested for use in nausea or vomiting in the palliative care patient:

1. Antiemetics should be given regularly if the nausea persists more than several hours a day.

2. If the first agent does not work completely additional agents should be added on rather than discontinued.

First line for use in patients on opioids, or those with gut mobility disturbance due to liver metastases, GI cancer etc.
Metoclopramide
10-20mg po/sc/IV qid
Domperidone
10-20mg po qid

Second line
Prochlorperazine
5-10mg po/pr q4-6h
Haloperidol .5-2mg po bid – q6hr
Methotrimeprazine 2.5-10mg po/sc bid-tid

Third line
Dexamethasone
4-8mg po/pr/sc/IV od-bid
Dimenhydrinate
15-50mg po/sc/IV q6hr

Fourth line
Hyoscine
0.125mg po q6hr
Transderm V patch

Ondanseton
8mg po/IV q8hr
Dolasetron
50-100mg po/IV once daily

For further reading, see textbook Medical Care of the Dying, 3rd edition, Downing (Ed) et al, Victoria Hospice Society, 1998 and Waller A, Caroline NL. , Handbook of Palliative Care in Cancer, 2nd edition, Butterworth Heinemann, Boston, 2000.

The Formulary Committee will collect information on the use of ondansetron in palliative care before a final decision is made to include it on the Palliative Care Formulary.

Please contact:
Dr. Romayne Gallagher
604-822-1603
email: romayne@interchange.ubc.ca

Genital specimens	Office and Laboratory Management of Genital Specimens
Helicobacter pylori	Detection and Treatment of Helicobacter pylori Infection in Adults
Hepatitis, viral testing	Viral Hepatitis Testing
Homocysteine	Use of Homocysteine Measurement in the Evaluation of Atherothrombotic Disease
House calls	House Calls, Reviewed and Unchanged April 2000
Iron	Use of Serum Ferritin and Total Iron and Iron Binding Capacity
Mammography	Use of Diagnostic Facilities for Mammography
Prenatal testing	• Prenatal Cytogenetic Testing, Revised 2000
	• Prenatal Ultrasound
Pre-operative testing	Routine Pre-Operative Testing, Revised 2000
Sleep disorders	• Assessment and Management of Obstructive Sleep Apnea in Adults, Revised 2000
	• Primary Care Management of Sleep Complaints in Adults
Stool testing for ova and parasites	Ova and Parasite Testing of Stool Samples
Throat sore	Diagnosis and Management of Sore Throat
Thyroid testing	Use of Thyroid Function Tests in the Diagnosis and Monitoring of Patients with Thyroid Disease
Urinalysis	Macroscopic and Microscopic Urinalysis and Investigation of Urinary Tract Infection

These guidelines were developed by the Guidelines and Protocols Advisory Committee, approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

Guidelines and Protocols Advisory Committee
1515 Blanshard Street 1-2 Victoria, BC V8W 3C8
E-mail: guidelines.protocols@moh.hnet.bc.ca
Telephone: (250) 952-1347
Fax: (250) 952-1417
Web site: www.hlth.gov.bc.ca/msp

AMENDMENT TO MEDICAL SERVICES PLAN RADIOLOGY CATEGORIES
Effective January 1, 2001

The Diagnostic Accreditation Program of the College of Physicians and Surgeons of B.C., the B.C. Radiology Society and the Medical Services Plan have agreed to the following realignment of radiology fee items within radiology categories I, II and III.

Category I/II

08520 Shoulder Girdle
08521 Humerus
08522 Elbow
08523 Forearm
08524 Wrist
08525 Hand (any part)
08530 Hip
08531 Femur
08532 Knee
08533 Tibia & Ankle
08534 Ankle
08535 Foot (any part)
08544 Pelvis
08550 Thoracic Viscera
08590 KUB

Category III

08500 Skull - routine
08501 Skull – special studies additional
08503 Paranasal Sinuses
08504 Facial Bones - orbit
08505 Nasal Bones
08506 Mastoids
08507 Mandible
08508 Temporo-Mandibular Joints
08509 Salivary gland region
08510 Sialogram
08511 Eye – for foreign body
08514 Naso-pharynx and/or neck, soft tissue-single lateral view
08518 Pre-MRI views of orbits to rule out foreign body
08536 Leg length films
08540 Cervical Spine
08541 Thoracic Spine
08542 Lumbar Spine
08543 Sacrum and Coccyx
08545 Sacro-Iliac Joint
08546 Scoliosis films on 14x36 film
08547 Pelvis and additional requested views (i.e. sacro-iliac joints, hip, etc.)
08549 Spine – requested additional views
08551 Thoracic Inlet
08552 TI – additional requested views
08554 Ribs – one side
08555 Ribs – both sides
08556 Sternum or Sterno-Clavicular joints
08557 Sternum and Sterno-Clavicular joints
08570 Abdomen
08571 Abdomen, multiple views
08526 Special requested views in upper extremity
08537 Special requested views in lower extremity
08603 Bone age
08604 Bone survey – 1st anatomical area
08605 Bone survey – each subs. anatomical area

Category IV – Includes all fee items in the Radiology Payment Schedule EXCEPT the following:

Bone Density

08688 Bone density – single area
08689 Bone density – second area
08696 Bone density – whole body

CT Scans
- restricted to approved and accredited hospitalbased facilities only
- professional fee only – payable regardless of patient accessioning (in or outpatient)

08690 Tomography – head scan without contrast
08691 Tomography – head scan with contrast
08692 Tomography – head scan, double scan or 2 plains
08693 Body scan one region without contrast
08694 Body scan one region with contrast
08695 Body scan double scan or two regions

UPDATE to the MSC PAYMENT SCHEDULE

PREAMBLE

The wording of Preamble A.1. is amended as follows:

Fee Payable by the Medical Services Plan

A *Payment Schedule* for medical practitioners is established under Section 21 of the *Medicare Protection Act* and is referred to in the *Master Agreement* between the Medical Services Commission (MSC) and the British Columbia Medical Association (BCMA). The fees listed are the amounts payable by the Medical Services Plan (MSP) of British Columbia for listed benefits. "Benefits" under the *Act* are limited to services which are medically required for the diagnosis and/or treatment of a patient, which are not excluded by legislation or regulation, and which are rendered personally by medical practitioners or by others delegated to perform them in accordance with the Commission's policies on delegated services. Services requested or required by a "third party" for other than medical requirements are not insured under the Plan. Services such as consultations, laboratory investigations, anaesthesia, surgical assistance, etc., rendered solely in association with other services which are not benefits also are not considered benefits under the Plan, except in special circumstances as approved by the Medical Services Commission (e.g.: Dental Anaesthesia Policy).

GENERAL SERVICES

Effective February 28, 2001 the following item is cancelled:

00038 Conjunctival test S7.41

GENERAL PRACTICE

Amendment

The cancellation date of the following item has been extended until September 30, 2001 or when replaced by a subsequent Minute, whichever occurs first:

P14545 Medical Abortion S95.32
Note: Includes all associated services rendered on the same day as the abortion. Includes consultation whenever rendered.

The following note is added to fee item 13052:
Note: See Anaesthetic Preamble regarding pre-Anaesthetic Evaluation fees.

ANAESTHESIA

Amendment

The following amendment is made to the Anaesthesia Preamble, Clause 1, regarding Pre-Anaesthetic Evaluation Fees:

01151 and 13052 apply when a pre-anaesthetic evaluation is performed for:
a) In-patients where a separate visit prior to anaesthesia is required. The assessment, when performed immediately prior to anaesthesia will be paid using the anaesthetic intensity/complexity level of the anaesthetic procedure itself and 01151 or 13052 will not be paid in addition.

Amendment

The following is deleted from the Section of Anaesthesia Preamble 13 and replaces as indicated:

13. Anaesthetic for non-insured dental procedures
General anaesthetic services will only be paid for non-insured dental procedures performed in a hospital or under a hospital's Day Care Service Program where a medical condition (American Society of Anaesthesiologists Classification - ASA three or above), physical and/or mental disability or the extremes of age would make it unsafe outside these settings.

If the dentist and the anaesthetist are of the opinion that a patient classified as American Society of Anaesthesiologists (ASA) 2 requires a hospital setting for the safe performance of dental procedures, then claims for anaesthetic services in these instances must be accompanied by a clear explanation of the reasons for providing a hospital based service.

The American Society of Anaesthesiologists (ASA) classification of physical status is as follows:

Class 1 - A healthy patient.
Class 2 - A patient with a mild systemic disease.
Class 3 - A patient with a severe systemic disease that limits activity but is not incapacitating.
Class 4 - A patient with an incapacitating systemic disease that is a constant threat to life.
Class 5 - A moribund patient not expected to survive 24 hours with or without operation.

Note: MSP policy for coverage of anaesthesia for non-insured dental services performed outside a hospital setting is currently under review. Until the review is completed, MSP will continue to cover medically required anaesthesia services in these circumstances.

The following Dental Anaesthesia Policy replaces the previous Anaesthesia Preamble 13.

13. Preface:

This policy is restricted to non-cosmetic non-insured dental procedures where it is impossible for the dentist or oral and maxillofacial surgeon to properly manage the patient by any other means except with general anaesthesia. The exceptions will apply to dental services regardless of the location in which they are performed.

Policy:

Dental related anaesthesia services are only a benefit when the dental procedure is an insured service under MSP unless one of the following exceptions exists:

i) children requiring extensive dental rehabilitation and could not be otherwise managed/treated due to the length of time for the treatment and the dental treatment is scheduled to last more than one hour; or
ii) the patient has a severe mental or physical disability that precludes the performance of the dental procedure(s) under local anaesthesia; or
iii) there is a demonstrated medical contra-indication (e.g. allergy) to local anaesthesia precluding the performance of the dental procedure(s) under local anaesthesia; or
iv) there is difficulty with access to the airway precluding the performance of the dental procedure(s); or
v) the presence of dental disease adds a significant risk of complication(s) to a planned major surgical procedure, medical treatment, or post-operative care such as for cancer treatment and/or the patient's presenting medical condition is severe enough to preclude the performance of the dental procedure(s) under local anaesthesia; or
vi) the emergent nature of the dental condition requires immediate attention under general anaesthesia.

Notes:
1. The term extensive dental rehabilitation will include surgery for trauma, fillings, and other traditional rehabilitation services.
2. Prior approval may be sought for those cases not fulfilling the exception criteria listed above when the dentist or oral and maxillofacial surgeon is of the opinion general anaesthesia is essential for the safe and efficient performance of a medically required dental procedure. It is important to note that fear and/or anxiety does not warrant coverage of dental anaesthesia by MSP. Requests for prior approval should be forwarded in writing (with appropriate documentation to make a decision) to the Director, Claims Branch, Medical Services Plan.
3. The Association of Dental Surgeons has agreed that in the case of an audit resulting in the recovery of inappropriately billed anaesthesia claims, the dental or oral and maxillofacial surgeon requesting the anaesthesia will be responsible for reimbursement. Recoveries will be applied to the Available Amount for physician services.

DERMATOLOGY

The following item has been approved on a provisional basis. This Minute will expire on October 31, 2001, or when replaced with a subsequent Minute, whichever occurs first:

P00228 Photo epilation of facial hair – per 1/4 hour (or major portion thereof) $25.48

Notes:
i. Billable to a maximum of 1/2 hour per session
ii Epilation of facial hair for familial hirsutism is not a benefit of the Plan
iii Pre-authorization is required (see Preamble B.16.2.(6))

OTOLARYNGOLOGY

The following item is deleted, effective June 30, 2001:

02523 Audiogram – tone decay

INTERNAL MEDICINE

The following modifications to the *Payment Schedule* have been approved, effective June 22, 2000:

The note following the indicated items is amended as follows:

Overnight home oximetry (continuous recording of oxygen and pulse)

P00910	– professional fee	$25.00
P00911	– technical fee	$14.00

Note: Fee items 00910 and 00911 are limited to Category III Pulmonary Function laboratories and/or polysomnography laboratories with the established personnel qualifications for such laboratories.

The following items have been approved on a provisional basis. This Minute will expire on October 31, 2001, or when replaced by a subsequent Minute, whichever occurs first.

Patient Activated Cardiac Event Recorders

P00362 Event/unmonitored loop recorders (first strip) – Professional Fee $32.45

P00369 - each additional strip (per strip) $16.23

Note: Additional strips are limited to two extra strips per patient, per two week period.

P00392 Event/unmonitored loop recorder – Technical fee $39.00

Notes:

i. The following notes apply to fee items 00362, 00369, 00392
ii. These items are intended to cover a two-week period
iii. Consultation not paid in addition
iv. Provide note record when more than one recording billed per patient, per year
v. Holter monitor not payable in addition
vi. An explanatory note is required for second test, same patient.

NEUROSURGERY

The following modifications to the Payment Schedule have been approved, effective September 28, 2000:

T03221 Implantation of vagal nerve stimulator – to include electrodes and stimulator $475.00 Anaes. Level 4

T03223 Replacement of stimulator component of vagal nerve stimulator $198.00 Anaes. Level 3

T03225 Removal of vagal nerve stimulator and electrodes $350.00 Anaes.Level 4

OBSTETRICS AND GYNAECOLOGY

The following items are deleted, effective June 30, 2001:

04113	Amniocentesis for termination of pregnancy
04122	Intrauterine operation - transfusion
04513	Vaginal repair of vesico-vaginal fistula
04403	Colpotomy - open

PLASTIC SURGERY

The following new fee item is effective May 1, 2001:

T06182 Ganglia of tendon sheath or joint $161.33 Anaes. Level 1

GENERAL SURGERY

Amendment

The following fee item has been cancelled, effective April 30, 2001:

P07056 Ganglia of tendon sheath or joint $161.33 Anaes. Level 1

DIAGNOSTIC RADIOLOGY

The following items are deleted, effective June 30, 2001:

08598	Placentogram (with or without contrast media)
08623	Retroperitoneal gas insufflation

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES

The following items are deleted, effective June 30, 2001:

00779	Amnioscopy
00725	Perirenal air insufflation – procedural fee

LABORATORY PROCEDURES

The cancellation date of the following item has been extended until July 31, 2001.

P91719	Glucose-2hr, post-75 g S18.05 Note: i) Restricted to Category IIC and Category III Laboratories.

NUCLEAR MEDICINE

The following note of the Nuclear Medicine Preamble is modified as follows:

7. Fee item 09877 (Repeat of major scan, no additional radionuclide) can only be billed with the following scans if additional (delayed) imaging is performed. Fee item 09877 may not used for SPECT.

i.	09806	Parathyroid imaging
ii.	09807	M.I.B.G. imaging (I131-metatodobenzyl-guanidine)
iii.	09817	Receptor imaging
iv.	09826	Tumour imaging
v.	09829	Adrenal imaging
vi.	09844	Red cell survival study
vii.	09867	Brain scan, static
viii.	09869	Pancreas scan, static
ix.	09886	Cisternography
x.	95015	Iodine 131 whole body scan
xi.	95055	Renal imaging with pharmaceuticals (isolated procedure)
xii.	95060	Renal imaging without pharmaceuticals (isolated procedure)
xiii.	95065	White blood cell labelled with radioisotope (if views are perfomed on separate days or 24 hours apart)
xiv.	09834	Bone scan (only if 24 hour views are performed)
xv.	09878	Liver clearance of H.I.D.A. (biliary scan) (if 24 hour views are performed)
xvi.	95025	Liver clearance of H.I.D.A. with pharmaceutical (if 24 hour views are performed)

TRAY FEES

The following item is deleted from the major tray fee list, effective April 30, 2001:

P07056	Ganglia of tendon sheath or joint

The following item is added to the major tray fee list, effective May 1, 2001:

06182	Ganglia of Tendon Sheath or Joint

The following items are added to the list of items eligible for a Major Tray Service fee, effective December 14, 2000.

00792	Cysto-ureterogram – technical fee
01140	Nerve Root or Facet Blocks: Cervical – single
01141	Nerve Root or Facet Blocks: Cervical – multiple
01142	Nerve Root or Facet Blocks: Thoracic – single
01143	Nerve Root or Facet Blocks: Thoracic – multiple
01144	Nerve Root or Facet Blocks: Lumbar – single
01145	Nerve Root or Facet Blocks: Lumbar – multiple
02341	Posterior Nasal Packing – To include Balloon Control of Epistaxis
02345	Drainage of Abscess or Haematoma of Septum
02346	Posterior Nasal Packing with Trans-Oral Gauze Pack, under Local, Topical or General Anaesthesia
02412	Biopsy of Larynx and/or Cauterization (including Laryngoscopy)
04032	Biopsy of Vulva, Excisional Lesion >/= 2 cm
04312	Resection of Labia Minora

04405	Removal of other Vaginal Cyst
04406	Operation for removal of Vaginal Septum
04510	Biopsy of Cervix, with Dilation and Curettage
07041	Aspiration: Abdomen or Chest

The following items are transferred from the list of Minor Tray Service fees to the list of items eligible for a Major Tray Service fee, effective December 14, 2000.

00701	Direct laryngoscopy – procedural fee
02317	Electrocoagulation of turbinates – one side
02318	Electrocoagulation of turbinates – both sides
02322	Removal of Nasal Polypi – Unilateral
02323	Removal of Nasal Polypi – Bilateral
02324	Antral lavage – unilateral
02325	Antral lavage – bilateral
02447	Incision of Periotonsillar Abscess – Under local Anaesthetic

The following items are added to the list of items eligible for a Minor Tray Service fee effective December 14, 2000:

00803	Loopogram
02210	Paracentesis of the ear drum

The following item is deleted from the list of eligible for a Major Tray Service Fee effective May 30, 2001:

02309	Radical antrostomy

CHRONIC DISEASE MANAGEMENT

The system-wide management of chronic illnesses requires the commitment and problem-solving abilities of all our health care professionals and coordinated efforts over time. Physicians are all too aware that the acute care system does not always meet the needs of people suffering from chronic illnesses, such as heart disease, diabetes, asthma and cancer. Emerging research shows that we can mitigate the complications of chronic disorders and improve the quality of life for patients, by actively involving patients in self-management.

The BCMA/MSC Joint Utilization Committee is responsible for the development and monitoring of utilization management initiatives that promote the efficient use of resources while maintaining or improving patient care. The Committee believes that a co-ordinated province wide approach to chronic disease management will improve the quality of life for these patients and, there-fore, has initiated a process to develop and implement tools for the management of chronic illnesses.

The following chart illustrates the Joint Utilization Committee's working approach to chronic disease management and identifies the first steps in the process.

Please see Chronic Disease Management Chart on page 20.

As part of this initiative, the Joint Utilization Committee is consulting with physicians (see enclosed survey) and other health professionals throughout the province who are exploring different ways of improving the quality of care for individuals with long term debilitating illnesses. Some of their experiences are described in this article.

Capital Health Region: Diabetes

The Department of Family Practice initiated a Diabetes Quality Improvement (QI) initiative when it was felt that the number of professionals in the field of endocrinology might be insufficient to meet our patient needs (the population with diabetes in the CHR is over 17,000). We found that education alone was not enough to change and improve practice. This led to a region-wide QI project funded by the CHR and involving all participants in diabetes care. The Chronic Care Model pioneered by the Group Health Cooperative of Puget Sound was adopted for this project. A year long "study-action" project was begun when Victoria joined with 28 other cities in the Institute for Healthcare Improvement's Collaborative on Improving Care of People with Chronic Disease. As a result of this investment in applied QI (1998-99), the region has made

Joint Utilization Committee: Chronic disease Management (CDM)

To improve quality of care & cost savings

- Data analysis
- Current practice
- Research

To manage chronic diseases

- Guidelines & Protocols
- Tools for physicians & patients

To meet management objectives

- Outcome measurement
- Patient satisfaction

Co-development of management plans with physicians

- Knowledge development
- Joint problem solving

Identify physician leaders in CDM	Profile CDM in MSP Physician's Newsletter	Survey physicians on CDM	Provide background information on CDM initiatives and results

major changes in our approach to chronic disease in general, and diabetes in particular. These include:

- improved population health data. By using Ministry of Health administrative and local lab data we now have a better idea of the number of people with diabetes in the region, the nature and extent of their morbidity, and costs to the community for their care. We also know a great deal more about the way in which their continuing care is monitored;
- improved delivery of family physician care. A group of 28 family physician volunteers analyzed their practice populations (average of 33 diabetic patients per physician) and piloted improved care and monitoring processes with their patients. This resulted in improvements in HbA1C and lipid testing rates, BP control and an understanding of smoking rates. This group confidentially reported to a family physician in the group, and the aggregated data was reported back to the whole department for their interest and education; and,
- improved staffing and services. The Diabetes Education Centre introduced improvements in the area of patient self-management, by developing education modules based upon client and staff feedback.

As a result of this physician initiated QI project, diabetes has been identified as a regional clinical priority, financial support has increased and care has improved for the whole population with diabetes in the CHR.

North Shore Health Region: Comprehensive Heart Function Program

Two years ago, the length of stay for Congestive Heart Failure (CHF) patients at Lions Gate Hospital exceeded the provincial average. An interdisciplinary team performed a chart review and discovered that admitted patients were not receiving optimal management while in hospital. The team found that:

- few echocardiograms were performed to support the diagnosis of CHF;
- less than ideal pharmaceuticals were utilized (even accounting for renal function); and,
- patient education was not being provided about the important role of daily weight monitoring (not performed in hospital) and a low sodium diet (also not prescribed in hospital) in staying well.

In September 2000, a six month pilot project was implemented with the goal of determining if a comprehensive, interdisciplinary program could improve the outcomes (length of hospital stay, readmission, and quality of life) for people living with congestive heart failure. The program included:

- more direction for in-hospital management with the use of pre-printed Physician Orders, and a Coordinated Care Timeline (care map);
- introduction of pharmacist, dietitian, and cardiac nurse consultations for evaluation and education of in-patients;
- formation of a Heart Function Clinic for interdisciplinary follow-up; and
- follow-up in the community by specially educated Home Care Nurses.

The budget for this project was minimal. Most of the professionals participating in the project were "on loan" from their departments. Physicians could refer inpatients or outpatients for follow-up at the Clinic for education. A registered nurse, medical doctor and pharmacist were present for all Clinic appointments. The physicians could consult with the pharmacists regarding the progression of optimal medication use and follow-up with renal function and other blood work, when indicated. The self-management skills of daily weight monitoring, low sodium intake and symptom management were reinforced with every visit. The pilot has shown that patients do much better when they have:

- self management skills;
- close medical follow-up and titration of medications;
- pre-printed orders and a timeline to guide in-hospital management; and,
- home care nurses.

Success has been evident in the number of patients who have shown an improvement in functional capacity and/or an improvement in NYHA class of heart failure. A Quality of Life (Minnesota Living with Heart Failure Questionnaire) research study will be completed in three months.

The above are two examples of successful chronic disease management initiatives. The Joint Utilization Committee would like to acknowledge and thank Dr. Art Macgregor, Dr Ken Woo and Mrs. Patti Phillips, RN, BSN, Cardiac and Diabetes Nurse Clinician, for their contributions to this article.

MSP BULLETIN

SUMMER 2001

The Medical Services Plan's "Bulletin" is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal "Agreement of Limitation" form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9029287062	06/52	F	06061
9029345046	05/43	F	06541
9029596344	09/55	M	06468
9030165823	12/54	F	05334
9030205973	05/54	M	09157
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07384
9034793801	06/59	F	06468
9034917099	02/49	F	00963
9035162781	06/34	F	01454
9035294522	07/58	M	05410
9041726364	07/56	F	03733
9052634089	06/39	M	00441
9071584167	06/48	M	09604
9084965077	12/53	M	05643